HEALTH APPRAISAL OF STUDENTS

STATEMENT OF PURPOSE:

All schools should establish a process for appraising the physical and mental health of the students and a process for providing health counseling to students and their parents/guardians.

AUTHORIZATION/LEGAL REFERENCE:

Vermont School Quality Standards, Section 2120.8.1.3.3

DEFINITION:

Health appraisal - the process of determining an individual's health status including physical, mental, and social health through such means as health history, parent, teacher and school nurse observations and screening procedures.

Health counseling – the process of providing guidance to students and families about eliminating or minimizing health problems that interfere with effective learning and help students to accept and adjust positively to their physical, mental and social conditions.

SUGGESTED SCHOOL NURSE/ASSOCIATE SCHOOL NURSE ROLES:

1. Collect information about the student's health status according to the screening requirements and school policies. (See screening section)
2. Evaluate the information obtained.
3. Notify parents about areas of concern.
4. Develop a health care plan with the family and the medical home if indicated and evaluate the care plan on a regular basis.
5. Reassess the student's health status as needed.
6. Encourage students /parents/guardians to establish and use a medical home on a regular basis for health supervision and ongoing care. Facilitate referral to medical home for students who do not have one. (See Medical/Dental Home section)

RESOURCES

Department of Health, Health Screening for Children & Adolescents Provider's Toolkit

SAMPLE POLICIES, PROCEDURES AND FORMS

- Primary School Health Entry Questionnaire
- Student Emergency Information Card

Primary School Health Entry Questionnaire
SCHOOL HEALTH ENTRY FORM - CONFIDENTIAL

Student's Name:_____Date: _____

Student's Doctor: _____Phone: _____

Student's Dentist: _____ Phone: _____

Please attach a current copy of student's immunization record or moral/medical exemption form (form is available at school on request). Immunization records and/or moral/medical exemption forms are required by Vermont Law.

Is the student currently being treated for any illness or condition the school should know about? ____ No ____ yes Doctor's name if different from above_____

Describe illness: _____

Is the student taking any medications? ___ No ___ Yes Medication _____

Medical History

1. Please describe anything unusual that occurred during pregnancy or at birth of this child. (i.e. bleeding, illness or drugs during pregnancy; low birth weight, premature birth, cord around neck, baby blue or yellow, R.H. negative, transfused, extended hospital stay)_____

2. Serious past illnesses: _____

3. Hospitalizations, operations (give age): _____

4. Serious accidents/injuries - (fractures, trauma to the head, poison ingestion)
_____no ____yes, if so please describe:_____

5. Allergies, Asthma triggers: _____
Medications: _____

6. Childhood illnesses (i.e. chicken pox, high fever, seizures, measles, scarlet fever, strep throat, pneumonia, frequent headaches or bloody noses) – give approximate age.
_____

7. Ears Infections? ___no ___yes infrequent (2-3/yr) ___ frequent (more than 3/yr) ___

Has hearing ever been tested? ___no ___ yes
Any hearing difficulties? ___no ___yes, describe_____

8. Eyes – Has vision been tested? ___no ___yes
Any vision or eye problems? ___no ___yes, describe glasses needed _____

9. Long-term or chronic illnesses or problems (i.e. diabetes, bed wetting, cystic fibrosis, head banging)
_____

_____

Describe care or medication needed : _____

_____

10. Physical or motor difficulties: _____

_____

11. Family History of:

Diabetes: _____

High blood pressure: _____

Heart disease: _____

Seizures: _____

Cancer: _____

12. Anything else we should know about your child? _____

_____

_____

Parent / Guardian Signature _____ Date _____

STUDENT EMERGENCY INFORMATION AND HEALTH UPDATE FORM

(A new card should be completed each year. Please notify the school if any information changes.)

PLEASE PRINT

Student's Name_____ Birth Date _____

Address_____ Telephone_____

Father_____ Telephone_____
Name Place of Employment Work Hours

Mother_____ Telephone_____
Name Place of Employment Work Hours

Regular day care/sitter name_____ Telephone_____

Please list two (2) nearby relatives or neighbors who will assume temporary care of your child if you cannot be reached.

1._____ Telephone_____
Name Address

2._____ Telephone_____
Name Address

Does your child have any health problem, illness, or disability that the school should be aware of?_____

Please explain how the condition should be managed at school._____

_____

Current Medications:_____

_____
(Name, dose, frequency)

Allergies:_____

Student Emergency Information Card

In case of accident or illness, I request the school to contact me. If not able to reach me, I hereby authorize the school personnel to seek emergency medical care, including notifying my child's doctor and transportation to the emergency room. I hereby authorize the physician in charge to administer whatever emergency treatment is necessary at my expense.

Signature of parent/guardian: _____ Date: _____

Date of recent immunizations: _____
(DPT, Td, MMR, HepB)

Does your child have health insurance? Yes _____ No _____

	Telephone	Last Seen	None
Child's Primary Care Provider			
Child's Dentist			

Siblings:	Last Name	First Name	DOB	Grade

Permission for Over the Counter Medications

My child has permission to receive the following medications at schools:

_____ Acetaminophen (Tylenol)
_____ Bacitracin antibiotic ointment
_____ Calamine Lotion (for insect bites)
_____ Chloroseptic lozenges (for sore throats)
_____ Benadryl (for allergic reactions)
_____ Robitussin DM cough syrup (for excessive cough)
_____ TUMS antacid
_____ Cough drops
_____ Visine A.C.
_____ Hydrocortisone cream for contact dermatitis
_____ Proxigel for canker sores

_____ _____
Parent/Guardian Signature Date